

Patient Name: _____

A. Diagnosis (Include ICD-10 codes that specifically address Manual Therapy Treatment)

Condition is related to: Injury Illness

Other: _____

B. Referring Health Care Provider (HCP)

HCP Name: _____

Provider #: _____

Address: _____

Phone: _____ FAX: _____

Email: _____

Reporting: After initial visit At end of prescription

Send by : Fax Mail Email

C. Medically Necessary Treatment: Implement Plan as Prescribed Below

Application (Direct and Indirect)

All of the Below

Head _____

Neck _____

Chest _____

Shoulders _____

Abdomen _____

Back _____

Low back/Hips _____

Upper extremities _____

Lower extremities _____

Other _____

Duration: 30 minute sessions 60 minute sessions

1x wk for ____ wks 2x wk for ____ wks 3x wk for ____ wks

2x month for ____ months 1x month for ____ months

Treatment Goals

Decrease pain

Decrease muscle tension/spasm

Decrease compensatory patterns

Increase mobility

Increase strength

Restore function

Restore posture

Maintain associated structures

All of the Above

Other _____

Specific Instructions:

HCP Signature: _____ **Date:** _____